Chapter Seven
Claims Submission and Billing

Chapter Overview

Introduction

This chapter provides information and instruction on the process of submitting Medicaid claims.

In This Chapter

This chapter covers the following topics:

Third Party Liability (TPL)

Third Party Liability Guidelines

Federal and state laws, rules, and regulations set out TPL requirements which require Medicaid to be the "payer of last resort." This means that all third parties including Medicare, CHAMPUS, Workers Compensation liability carriers, and private health insurance carriers must pay before Medicaid may pay. Additionally, providers must report any such payments from third parties on claims filed for Medicaid payment.

Medicaid-Allowed Amount

If the Medicaid-allowed amount is more than the third party payment, Medicaid will pay the difference up to the Medicaid-allowed amount. If the insurance payment is more than the Medicaid-allowed amount, Medicaid will not pay an additional amount.

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Third Party Liability, Continued

Noncompliance Denials

State and federal third party liability laws prohibit Medicaid from paying for services denied by private health plans due to failure to comply with those plan requirements. If the provider's service would have been covered and payable by the private plan, but some requirement of the plan was not met, Medicaid will not pay the service.

If the recipient has a private plan and does not inform the provider of such plan, and if the plan's requirements were not met because the provider was unaware of them, the provider may bill the recipient for those services if both the private plan and Medicaid deny payment due to noncompliance.

Similarly, if the recipient fails to cooperate in any way in meeting any private plan requirement, the provider may bill the recipient for the service(s). If, however, the recipient does present the private payer information to the provider and that provider knows that he or she is not a participating provider in the plan or cannot meet any other of the private plan requirements, the provider must inform the recipient of such and also tell the recipient that he or she will be responsible for payment of services.

How To Know If Third Party Liability Exists

The following suggestions help determine if a Medicaid recipient has third party liability:

1. Recipient's Medicaid Identification (MID) card lists in the Insurance Data block up to three health and/or accident insurance policies and Medicare Part A and/or Part B applicable to the recipient(s). Insurance information on the card will include:
    - insurance company name (by code)
    - insurance policy number
    - insurance type (by code)
    - recipient covered by policy
2. When services are rendered, providers should ask the recipient if he or she has any additional health insurance coverage or other third party liability. If health insurance is indicated, the provider bills the carrier before billing Medicaid. Before filing a claim with Medicaid, the insurance company must pay the claim or issue a written denial to the provider.
3. Provider Remittance Advice—when a claim is denied for other insurance coverage (EOB 94), the provider of service will receive a Remittance Advice indicating the other insurance company (by code), the policyholder name, and the certificate or policy number.

An "Insurance Company Code Book" can be obtained from Third Party Recovery at DMA upon request. The code book has a 2-digit "key" for the types of insurance coverage listed on the MID card.

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Third Party Liability—Commonly Asked Questions

1. **Q:** Why did my claim deny for EOB 094 "Refile indicating insurance payment or attach denial?"

A: EDS/DMA's database indicates the recipient had third party insurance on the date of service for which you are requesting reimbursement. Our records show this type of insurance should cover the diagnosis submitted for payment. If the type of insurance indicated could cover your service, you **must** file a claim with that insurance company prior to billing the Medicaid Program. If you receive a denial or payment for less than your charges, bill the Medicaid Program and, if appropriate, your claim will be processed and paid. It is the provider's responsibility to secure any additional information needed from the Medicaid recipient to file the claim.

If the insurance data was not indicated on the MID card, it was entered on the database after the MID card was printed and should be on the next MID card. You may also find this insurance information on your denial RA. **Note: This denial does not refer to Medicare.**

2. **Q:** How do I determine the name of the third party insurance company that is indicated on the recipient's MID card?

A: An Insurance Code Book is available upon request from the Third Party Recovery Section, DMA, P.O. Box 29551, Raleigh, NC 27626-0551 (Fax number 919-715-4725). This code book is a key to the code that is listed on the MID card in the insurance data block under the subheading "Name Code."

3. **Q:** How do I determine what type of insurance the recipient has?

A: The blue and pink MID cards list an insurance name code, policy number, and type of insurance code. The buff MID card lists the insurance name code only. The insurance type codes are listed below. This is a key to be used by the providers in identifying third party resources as shown by the code on the MID card in the insurance data block under the subheading "Type." See Chapter Two, Blue and Pink MID Cards – Explanation of Fields for a list of codes.

If you have questions, call the DMA Third Party Recovery Section (TPR), Cost Avoidance Unit. See Appendix B for telephone numbers.

4. **Q:** What do I do when my claim denies for EOB 094 and no insurance is indicated on the MID card?

A: Refer to the RA that showed the claim denying for EOB 094. The insurance information, the policyholder's name, certification number, and a three digit insurance code are listed below the recipient's name. The Third Party Recovery Section furnishes a third party insurance code list to providers upon request.

5. **Q:** What is considered an acceptable denial from an insurance company?

A: An acceptable denial is a letter or EOB from the insurance company or group/employers on company letterhead, which also complies with the policy, reflected in question 6. If a denial is questionable, such as a returned claim with "applied to deductible" written in, the claim should be forwarded to the Third Party Recovery Section, DMA, P.O. Box 29551, Raleigh, NC 27626-0551.

If the provider has an acceptable denial or EOB, attach the denial to the claim and forward to Provider Services Unit, EDS, P.O. Box 300009, Raleigh, NC 27622

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Third Party Liability—Commonly Asked Questions, continued

6. **Q:** Why did my claim deny for TPL after I included an insurance denial as referred to in # 5?

A: Due to Federal law interpretation changes, Medicaid denies payment for any service which could have been paid for by a private plan had the recipient and/or provider complied with the private plan's requirements. Examples of common private plan noncompliance denials include: failure to get referral from a primary care physician; non-participating provider; failure to acquire a second opinion; failure to acquire preapproval, etc. In these circumstances, the provider may bill the recipient for these services provided the noncompliance was not due to provider error, and/or appeal to the private plan.

It may be the provider's responsibility to secure such things as pre-approval, referral from a primary care physician or to fulfill other requirements of the private plans.

7. **Q:** What are the uses of the DMA-2057 form (Health Insurance Information Referral Form) and where do I obtain copies?

A: The DMA-2057 form should be completed in the following instances:

- When a written denial is unattainable;
- To delete insurance information, (i.e., a recipient no longer has third party insurance, but the MID card indicates other insurance);
- To add insurance information, (i.e., a recipient has third party insurance that is not indicated on the MID card);
- To change existing information, (i.e. a recipient has Major Medical third party coverage that is type coded as vision coverage only on the MID card.)

DMA-2057 forms can be ordered from your service relations analyst by calling 1-800-688-6696.

8. **Q:** If the Medicaid recipient's private health insurance company pays the recipient directly, what may I bill the recipient?

A: If the amount of the insurance payment is known, you may bill the recipient for that amount only. You may also file your claim to Medicaid indicating the third party payment amount in the appropriate block on your claim form and Medicaid will pay the Medicaid allowable amount, less the insurance payment. If the insurance payment is unknown, you may bill the patient the total charges until the payment amount is known.

9. **Q:** May I have an office policy stating I will not accept Medicaid in conjunction with a private insurance policy?

A: No. Federal regulation 42 CFR 447.20(b) stipulates a provider may not refuse Medicaid covered services to an individual who is eligible for medical assistance on account of a third party's potential liability for the service(s).

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Third Party Liability—Commonly Asked Questions, continued

10. **Q:** What do I do when a recipient, or other authorized person, requests a copy of a bill that I submitted to Medicaid?

A: If you have submitted the claim to Medicaid already, whether you have received payment yet or not, and if you have the proper patient authorization, you may provide a copy of the bill to the recipient, an insurance company, an attorney, or other authorized person, ONLY IF you comply with the following requirement. All copies of any bill which has been submitted to Medicaid MUST state "MEDICAID RECIPIENT, BENEFITS ASSIGNED" in large, bold print on the bill. If you provide a copy of a bill that was filed with Medicaid without this language, Medicaid may recoup this payment.

11. **Q:** How do I determine the amount of refund due Medicaid when Medicaid pays my claim and I receive payment subsequently from a third party liability carrier?

A: Once you have filed a claim with Medicaid and have received payment, your claim has been paid in full. Upon receipt of payment from the third party liability carrier, you must refund to Medicaid the amount of Medicaid's payment and you must also refund to the patient or the liability carrier any remaining amount. By billing Medicaid and receiving payment, the provider relinquishes any right upon Medicaid's payment for that service through assignment and subrogation. This includes the prohibition on the provider billing for or receiving a recovery for the difference between the amount Medicaid paid and the provider's full charges. This practice violates both State and Federal laws.

However, the provider has the option to defer billing Medicaid and instead pursue a claim for full charges with the liability carrier. However, as long as the provider has filed a claim with the liability carrier within one year from date of service, and is diligently pursuing reimbursement from that liability carrier, the provider may file a claim with Medicaid within 180 days of a denial or payment from that carrier, even though it may be greater than the 12-month time limit for filing with Medicaid.

Claim Submission

General Information

All ambulance providers are required to use the UB-92 claim form when submitting claims for services rendered to a recipient.

Claims may be submitted by paper or electronically.

Submit only one (1) ambulance trip on each UB-92 claim form.

Bill base and mileage, if applicable, for each ambulance trip on the same form.

Complete all required form locators as directed in the billing section of this manual.

Refer to Appendix A for ambulance and condition codes for use in completing the UB-92 claim form.

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Claim Submission, continued

Recipient Has Medicare

Medicare claims cross over automatically to Medicaid if the provider's Medicare number is cross-referenced to their North Carolina Medicaid provider number in Medicaid's cross-reference files.

When billing for ambulance services rendered to a recipient with both Medicare and Medicaid coverage, use of condition code 89 in block 24 of the UB-92 form eliminates the need to attach a Medicare denial voucher. The condition code 89 indicates that the provider has billed Medicare and has received a denial.

Recipient Has Other Coverage

If recipient has other forms of ambulance coverage such as insurance, show payment in block 54 of the UB-92 form, or attach voucher showing payment. If insurance denied, attach voucher showing the denial.

Call Reports

Call reports are not required with the UB-92 form. They must be kept on file for five (5) years, substantiate the billing codes, and be provided to DMA or it's agents upon request.

Electronic Claim Submission

Electronic Claim Submission (ECS) is the process of submitting claims through electronic media. Claims are processed through Modem, magnetic tape, and diskette formats. A provider agreement must be completed and returned to DMA before billing electronically.

UB-92 software for ambulance services is available through the ECS unit at EDS. Ambulance software for non-emergency, emergency ground transport, emergency air transport, or state-to-state placement can be obtained from the Electronic Claims unit. See Appendix B for telephone numbers. Before using software from a vendor, contact the ECS unit at EDS for a copy of the specifications.

Prior to billing electronically for payment, EDS will process provider supplied test claims to determine software formatting errors. Refer to Appendix B for important telephone numbers for electronic claims submission.

Electronic Funds Transfer

This process enables the ambulance services provider to receive Medicaid payments through automatic bank deposit. The Remittance and Status report is mailed to the provider's current mailing address.

Paper Claim Submission

Follow billing instructions included in this manual.

Signature on File

Providers may file paper claims without an individual signature on each claim if the provider has submitted a "Provider Certification for Signature on File".

The certification must contain the provider's original signature; stamped signatures are not accepted. See Attachment C for a certification form.

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Claim Submission, continued

Processing Claims Without Signature

The system is annotated to indicate the certification for signature is on file. All claims are checked for the signature on file indicator. If a signature on file certification form has not been received and the claim has no signature, it will be denied.

Contact EDS Provider Relations with questions concerning completion of the certification. See Appendix B for telephone numbers.

Time Limit

EDS must receive all Medicaid claims except hospital inpatient and nursing home claims within 365 days of the date of service in order to receive payment.

Time-limit Overrides

DMA and EDS have limited authority under federal regulations to override the billing time limit. The following are examples of acceptable documentation to review for time-limit override:

- correspondence about the specific claim received from DMA and/or EDS
- an explanation of Medicare benefits or other third party benefits dated within 180 days from the date payment or denial
- a copy of the Remittance Advice (RA) showing the claim pending or denied (the denial must be for reasons other than the time limit)

Claims with attachments for time-limit overrides must be sent to EDS Provider Services. See Appendix B for address and contact number.

Submitting a billing date on claims only or a copy of the office ledger is not acceptable documentation. Submission dates do not verify that the claim was received within the 365-day time limit

See the Medicaid Inquiry section of this Chapter.

Billing Instructions

Revenue Code (RC), Form Locator 42

Use the 3 digit code that best describes the ambulance classification.

See Appendix A for codes.

HCPC Code, Form Locator 44

Use the 5 digit code that further identifies the service being rendered.

One (1) base rate and one (1) mileage code, if applicable, is filed per claim form. The base rate and mileage codes should be for the same level of service. Example: Both BLS codes or both ALS codes.

Record time of pick up in form locator 18.

See Appendix A for codes.

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Billing Instructions, continued

Condition Codes, form Locator 24 - 30

Use up to seven (7) codes that best defines the circumstance, situation, and/or qualifying criteria of the transport.

Condition codes should be directly related to the level of transport provided. The call report substantiates the codes used.

At least one (1) condition code should be a qualifying criteria and/or situation.

See Appendix A for codes.

UB-92 Claim Form Completion

UB-92 Claim Form

See Attachment F at the end of this chapter for a sample completed UB-92 claim form.

Review the descriptions of form locators as they apply to ambulance providers. All required fields must be completed. Incomplete claim forms may result in denial.

See the Appendix for necessary codes to complete the UB-92 claim form.

Directions

These instructions will assist ambulance providers billing Medicaid. Only form locator fields that apply to ambulance providers are listed and described.

Form locators listed correspond with the numerical field on the paper UB-92 claim form.

The numbers are in numerical sequence.

Complete UB-92 Manual

A complete manual may be obtained through the North Carolina Hospital association at 1-919-677-2400.

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Instructions for Completing the UB-92 Claim Form

Form Locator/Description	Requirements	Remarks
1. Provider Name/Address	Required	Name and 1-3 lines of address. Use name as it appears on the Remittance Advice (RA). Do not abbreviate.
3. Recipient Control Number	Optional	Recipient control number or medical record number which the provider has elected to appear on their R/A. This number will be keyed by EDS and reported back to the provider in the medical record field of the R/A. This field will hold up to 20 digits alpha or numeric. Only the first nine digits of this number will appear on the RA.
4. Type of Bill	Required	Ambulance bill type is 131.
6. Statement Covers Period	Required	Enter date of service in both from and through spaces. Only 1 date of service per claim. Enter MMDDYY - Example January 1, 1999 would be indicated as 010198 (Future Notification of increase to 8 bytes for Y2K compliance - MMDDYYYY will be forthcoming)
12. Recipient Name	Required	Enter recipient's name exactly as shown on the MID card; last name, first name, and middle initial. Please do not use nicknames.
18. Admission Hour	Required	For multiple transports on the same day, submit each trip on a separate claim. Record the time of pickup, using the code listed below. Code AM Code PM 00 12:00 - 12:59 Midnight 12 12:00 - 12:59 Noon 01 01:00 - 01:59 13 01:00 - 01:59 02 02:00 - 02:59 14 02:00 - 02:59 03 03:00 - 03:59 15 03:00 - 03:59 04 04:00 - 04:59 16 04:00 - 04:59 05 05:00 - 05:59 17 05:00 - 05:59 06 06:00 - 06:59 18 06:00 - 06:59 07 07:00 - 07:59 19 07:00 - 07:59 08 08:00 - 08:59 20 08:00 - 08:59 09 09:00 - 09:59 21 09:00 - 09:59 10 10:00 - 10:59 22 10:00 - 10:59 11 11:00 - 11:59 23 11:00 - 11:59 99 Hour Unknown **Note: Code 99 is not acceptable for Ambulance providers to use.**

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Instructions for Completing the UB-92 Claim Form, continued

Form Locator/Description	Requirements	Remarks
23. Medical Record Number	Not Required	List medical record number. Only for your personal use.
24-30. Condition Codes	Required where applicable	Ambulance Claims Condition codes are used to replace the information reviewed on the call report. They are grouped as follows: 81 - 87 Describe weather, time, and hospital conditions that make transport necessary. 90 - 95 Situation codes are used to best describe the recipient's circumstance at time of arrival. 96 - 98 Qualifying criteria - describe services and treatments rendered to the recipient. Record appropriate condition codes in form locators 24 - 30. At least 1 code from 90 - 98 must be listed. You should list as many codes as needed to justify that transportation by any other means would endanger recipient's health or life. Be as thorough as possible. You may list up to 7 codes. Your call report must substantiate your listings. 81 **Weather, road or traffic conditions cause a delay:** Enter this code when there are specific traffic conditions or obstacles, (snow and ice, closed road, etc.) which would present a delay in the recipient's access to needed care. Enter the specific traffic condition or obstacle in the remark section of the claim. 82 **Time needed to transport poses a threat:** Enter this code when the time required to transport the recipient by land endangers the recipient's life or health. As a general guideline, when land transport requires 30 - 60 minutes. 83 **No beds available at transporting hospital:** Enter this code when the recipient requires admission and there are no beds available at the transporting hospital. 84 **No beds available at nearest hospital:** Enter this code when the recipient is transported to other than the nearest hospital because no beds are available at that hospital. 85 **Transporting hospital unable to provide required treatment:** Enter this code when the recipient requires specialized treatment and/or physician is unavailable at the transporting hospital.

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Instructions for Completing the UB-92 Claim Form, continued

Form Locator/Description	Requirements	Remarks
24-30. Condition Codes, continued	Required where applicable	86 **Nearest hospital unable to provide required treatment:** Enter this code when the recipient requires specialized treatment and/or physician is unavailable at the nearest hospital as well as the transporting hospital. 81 **Medicare Part B non-covered service or does not meet Medicare criteria for Part B:** This code is used for Medicare and Medicaid. 90 **Situation: Accidents/acute injuries/ trauma.** (e.g. fractures, crushing injuries, obvious multiple injuries, drowning, burns, poisoning) 91 **Situation: Overdose** 92 **Situation: Acute Illness - Identifies sudden onset. Relatively severe course.** (e.g.: sudden altered level of conscious or mental status, severe chest pain, paralysis.) 93 **Situation: OB** (delivery or crowning**)/Rape** (with or without of hemorrhage or other trauma) 94 **Situation: Chronic illness with an acute episode** (such as prolonged or witnessed seizures, unstable symptomatic blood sugar, respiratory distress) 95 **Situation: Transfer requiring stretcher for recipients unable to travel by another means for transfer for medical services** 96 **Qualifying cirteria: Use of gauze pads/bandages; horizontal immobilizers, splint, or restraints for combative recipients** 97 **Qualifying criteria: Administration of Medication(s), IV's, Venous blood draws, EKG, anti-shock measures, CPR, defibrillation, establish and maintain an airway, pacing, cricothyrotomy, nebulizer and/or needle thoracostomy** 98 **Qualifying criteria: Unstable vital signs monitored enroute, O_2 applied and/or blood glucose monitored**

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Instructions for Completing the UB-92 Claim Form, continued

Form Locator/Description	Requirements	Remarks
32-36. Occurance codes	Required where applicable	Required for 3rd party denials - a code and associated date defining a significant event relating to this bill which may affect payer processing. Enter date as MMDDYY. (Future Notification of increase to 8 bytes for Y2K compliance: MMDDYYYY will be forthcoming) 24 Date insurance denied: Enter this code indicating the date on the EOB stating the denial of coverage by the provider for any insurer 25 Date Benefits terminated by Primary Payer: Enter this code indicating the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient
39-41. a-d Value Codes and Amounts	Required where applicable	Enter any value code pertinent to this claim. Applicable deductible/recipient liability amounts should be indicated in this Form Locator block with a value code of 23. 14 No Fault, Including Auto/Other, or Any Liability Insurance: Amount shown is that portion from a higher priority, no-fault including auto/other, or liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. 23 Recurring Monthly Income: Medicaid-eligibility requirements to be determined at state level. (Only for Medicaid) 41 Black Lung: Code indicates the amount shown is that portion of a higher priority Black Lung payment made on behalf of a Medicare beneficiary that you are applying to covered Medicare charges on this bill. If six zeros (000000) are entered in the amount field, the provider is claiming a conditional payment because there has been a substantial delay in its payment. 42 VA: Code indicates the amount shown is that portion of a higher priority VA payment made on behalf of a Medicare beneficiary that you are applying to covered Medicare charges on this bill. 43 Disabled Beneficiary Under Age 64 with LGHP: Code indicates the amount shown is that portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that you are applying to covered Medicare charges on this bill.

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Instructions for Completing the UB-92 Claim Form, continued

Form Locator/Description	Requirements	Remarks
39-41. a-d Value Codes and Amounts, continued	Required where applicable	47 Any Liability Insurance: Amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. Enter six zeros (000000) in the amount field if you are claiming a conditional payment. (Note: The decimal is implied and refers to the dollar and cents delimiter.) 68 EPO-Drug: Number of units of EPO administered during the billing period. Report amount in whole units to the left of the dollar/cents delimiter. A1 Deductible Payer A: The amount assumed by the provider to be applied to the recipient's deductible amount involving the indicated payer. B1 Deductible Payer B: The amount assumed by the provider to be applied to the recipient's deductible amount involving the indicated payer. C1 Deductible Payer C: The amount assumed by the provider to be applied to the recipient's deductible amount involving the indicated payer. A2 Coinsurance Payer A: The amount assumed by the provider to be applied to the recipient's coinsurance amount involving the indicated payer. B2 Coinsurance Payer B: The amount assumed by the provider to be applied to the recipient's coinsurance amount involving the indicated payer. C2 Coinsurance Payer C: The amount assumed by the provider to be applied to the recipient's coinsurance amount involving the indicated payer.
42. Revenue Code	Required	Enter the appropriate R/C codes RC540 Ambulance general classification RC542 Ambulance/medical transport RC543 Ambulance/heartmobile RC544 Ambulance/oxygen RC545 Air Ambulance RC546 Ambulance/neonatal RC549 Ambulance/other RC001 Total charges

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Instructions for Completing the UB-92 Claim Form, continued

Form Locator/Description	Requirements	Remarks
44. HCPC/Rates	Required	Enter applicable HCPCS code for Ambulance. Every RC code entered in FL42 must have a corresponding HCPC code in FL44. HCPC Procedure Code Ground Description A0090 Non-emergency mileage outside base area; one way A0320 Ambulance service, BLS, non-emergency transport, supplies included, mileage separately billed; one-way base rate A0322 Ambulance service, BLS, emergency transport, supplies included, mileage separately billed; one-way base rate A0324 Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, supplies included mileage separately billed; one-way base rate A0326 Ambulance service, ALS non-emergency transport, specialized ALS services rendered supplies included, mileage billed separately. Indicates qualifying criteria for KVO A0330 Ambulance service, ALS, emergency transport, specialized ALS serviced rendered, supplies included mileage separately billed; one way base rate A0380 BLS mileage (per mile) outside base area; one-way A0390 ALS mileage (per mile) outside base area; one-way Y0001 Non-emergency transport round-trip Y0002 State-to-State placement; needs PA; base rate one-way Air Description A0040 Helicopter, lift off Y0050 Helicopter, per nautical mile Y0060 Fixed Wing, lift off Y0070 Fixed Wing, per nautical mile Y0003 Fixed Wing, lift off, state-to-state placement Y0004 Helicopter, lift off, state-to-state placement

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Instructions for Completing the UB-92 Claim Form, continued

Form Locator/Description	Requirements	Remarks
46. Unit of Service	Required	Enter number of units for each mileage code. 1 Unit = 1 mile (No units are required for base codes)
47. Total Charges	Required	The total of the amounts in this column are added and recognized by the Revenue Code 001. In field 42
50. a, b, c Payer A, B, C	Required	Enter Payer Classification Code and Specific Carrier Identification Codes of each of up to three payers listed in order of priority. Payer information entered on lines a, b, or c should correspond with any information indicated in form locators 37, 52-66. A Primary payer B Secondary payer C Tertiary payer Payer Classification Codes Medicare……..……M Medicaid……..……D Blue Cross……..…….B Commercial Insurance……..…..I CHAMPUS……....C NCDEHNR-Purchase of Care……...N Worker's Compensation……....W State Employee Health Plan……..E Administered Plans……S Health Maintenance Organization….H Self Pay/Indigent/Charity……..P Other……..O

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Instructions for Completing the UB-92 Claim Form, continued

Form Locator/Description	Requirements	Remarks
50. a, b, c Payer A, B, C, continued	Required	Specific Carrier Identification Codes Carrier Payer Classification / Code / Explanatory Notes Medicare (M) 0000 4 zeros Medicaid (D) XX00 Where XX = postal state code Blue Cross (B) 0XXX Where XXX = Blue Cross Plan Code or FEP Commercial Insurer (I) XXXX Where XXXX = Docket Number Commercial Insurer (I) 9999 When docket number is unassigned CHAMPUS (C) 0000 4 zeros NCDEHNR-Purchase of Care 0000 4 zeros Worker's Compensation XXXX Where XXXX = Docket Number Worker's Compensation 9999 When docket number is unassigned State Employees Health Plan 0000 4 zeros Administered Plan (S) 0000 4 zeros Health Maintenance Organization (H) XXXX Where XXXX = Docket Number Health Maintenance Organization (H) 9999 When docket number is unassigned Self-Pay/ Indigent/Charity (P) 6666 Self pay-hospital bills patient and expects payment **Note: Enter DNC00 for North Carolina Medicaid**
51. a, b, c Provider Number	Required	Number assigned to provider by Medicaid as shown on the RA. Do not use extra zeros or dashes.
54. a, b, c Prior Payments – Payers and Recipient	Required where applicable	Any applicable commercial insurance amount should be indicated. Amounts entered in this block will be deducted from the allowable payment. Do not enter previous Medicare or Medicaid payments.
55. Estimated Amount Due	Required where applicable	The amount estimated by the provider to be due from indicated payer.

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Instructions for Completing the UB-92 Claim Form, continued

Form Locator/Description	Requirements	Remarks
58. a, b, c Insured's Name	Required where applicable	Enter policyholder name for commercial insurance policy if Medicaid is not primary payer.
59. Recipient's Relationship to Insured	Required where applicable	Enter recipient's relationship to the insured if Medicaid is not the primary payer. 01 Patient is Insured Self-explanatory. 02 Spouse Self-explanatory. 03 Natural Child/Insured Financial Responsibility Self-explanatory. 04 Natural Child/Insured does not have Financial Responsibility Self-explanatory. 05 Step Child Self-explanatory. 06 Foster Child Self-explanatory. 07 Ward of the Court Recipient is ward of the insured as a result of a court order. 08 Employee Recipient is employed by the insured. 09 Unknown Recipient's relationship to the insured is unknown. 10 Handicapped Dependent Dependent child whose coverage extends beyond normal termination age limits as result of laws or agreements extending coverage. 11 Organ Donor Code is used in cases where bill is submitted for care given to organ donor where such care is paid by the receiving recipient's insurance coverage.

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Instructions for Completing the UB-92 Claim Form, continued

Form Locator/Description	Requirements	Remarks
59. Recipient's Relationship to Insured, continued	Required where applicable	Recipient's relationship to the insured, continued 12 Cadaver Donor Code is used where bill is submitted for procedures performed in cadaver donor where such procedures are paid by the receiving recipient's insurance coverage. 13 Grandchild Self-explanatory. 14 Niece/Nephew Self-explanatory. 15 Injured Plaintiff Recipient is claiming insurance as a result of injury covered by insured. 16 Sponsored Dependent Individual not normally covered by insurance coverage but coverage has been specially arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer. 17 Minor Dependent of a Minor Dependent Code is used where recipient is a minor and a dependent of another minor who in turn is a dependent (although not a child) of the insured. 18 Parent Self-explanatory. 19 Grandparent Self-explanatory. 20-99 Reserved for National Assignment
60. a, b, c Certificate/Social Security/ Health Insurance Claim/ Identification Number	Required	Enter 10 digit Medicaid ID number as indicated on recipient's MID card.
61. a, b, c Insured Group Name	Required where applicable	Enter applicable commercial insurance information if Medicaid is not primary payer.
62. a, b, c Insurance Group Number	Required where applicable	Enter applicable commercial insurance information if Medicaid is not primary payer.
63. a, b, c Treatment Authorization Code	Required where applicable.	Enter applicable nine-digit prior approval number. For out of state placement transport only.
67. Principal Diagnosis Code	Required	Code V719 should be entered for all Ambulance Services claims.
84. Remarks	Not Required	Enter any information applicable to specific claim billed.
85. Provider Representative Signature	Required	A written signature is required, however, a signature stamp is acceptable.
86. Date Bill Submitted	Desired	Enter date the claim was submitted.

Remittance and Status Report

Introduction

The Remittance and Status report, or Remittance Advice (RA), is a computer-generated document sent to providers showing the status of all claims submitted to EDS and a detailed breakdown of payments. See Attachment E for a sample RA.

How RAs Are Mailed

The RA is produced at the same time checks are issued. If the RA is ten pages or less for any checkwrite, it will be mailed with the check. If more than ten pages, the RA will be mailed under separate cover.

Record Keeping

Retain all RAs in chronological order to assist in keeping all claims and payment records current. If after checking the RA, a provider does not find information on questions about claims payment, contact the Provider Relations Unit at EDS for assistance.

1099 Form

The last RA received each year serves as the annual 1099 Form.

Parts of the RA

Introduction

Information on the RA is identified by subject headings. Each major subject heading is further divided into subsections depending upon provider and/or claim type:

- Paid Claims
- Adjusted Claims
- Denied Claims
- Returned Claims
- Claims in Process
- Financial Items
- Claims Summary
- Claims Payment Summary

Paid Claims

This section shows all claims that have had payment activity since the previous checkwrite.

- each subsection is sequenced alphabetically by the recipient's last name
- each subsection has summary totals
- a grand total summary of all paid claims subsections appears at the end of the paid claims section

Adjusted Claims

This section shows the status of claims when requests for action have been made to correct overpayments, underpayments, or payment to the wrong providers.

Some of the most common causes of adjustments are clerical errors, incorrect claims information, and incorrect procedure coding.

There are no subsections under this heading.

Continued on Next page

Parts of the RA, continued

Denied Claims

This section identifies those claims denied for payment.

1. Common reasons for claims denial are:
   - eligibility status
   - billing for noncovered services
   - expired filing time limits
2. Claims in this section are divided into subsections to indicate the type of bill processed.
3. Recipient names are sequenced alphabetically in each subsection.
4. Zero will appear in all columns to the right of "Non-Allowed."
5. An explanation code specifying the reason for denial will appear in the far right column.

Denied claims are final, and no additional action will be taken on the claims unless the provider resubmits.

Returned Claims

This section lists claims that cannot be processed by EDS for reasons such as missing medical records or omitted signatures. An unprocessed claim appears only once on the RA unless the provider resubmits it with the correct information; it will then appear as pending, paid, or denied.

Claims In Process

This section lists those claims, which have been received and entered by EDS but are pending payment because further review of the claims is needed. Claims appearing in this section should not be rebilled.

Financial Items

This section contains a listing of payments refunded by providers, amounts being recouped since the previous checkwrite, and other recoupment activities being applied which will reflect negatively on the provider's total earnings for the year. The explanation code beside each item indicates what action was taken.

Claims Summary

The claims summary is divided into inpatient and outpatient subsections and includes summary totals of revenue codes listed on the claims.

Claims Payment Summary

This section summarizes all payments and credits made to the provider by the Medicaid program for the specific pay period, entitled "Current Processed," and for the year, entitled "Year To Date Total."

Claim Resubmission

Denied Claims

Claims not meeting required criteria will be denied. The Explanation of Benefits (EOB) will inform the provider why the claim denied.

All information listed on the UB-92 must be substantiated on the call report. Refer to the EOB's and instructions in the following chart.

EOB	MESSAGE	ACTION
021	Duplicate of claim-system	Submit as an adjustment; include copies of call reports substantiating the trip billed. Include your RA and Adjustment/Inquiry form
023	Service requires prior approval (PA)	
459	Less severe dupe/ same DOS/ same admit hour	Submit as an adjustment; include copies of call reports substantiating the trips billed. Include your RA and Adjustment/Inquiry form
1060	Admit hour/time of pickup is missing or invalid	Correct field 18 using the applicable code for the time of pick-up. Resubmit as anew claim
1061	Only one date of service is allowed per claim	Bill each ambulance trip on a separate claim. Resubmit as new claim
1120	Duplicate billing of base trip has previously been paid	If multiple trips, submit adjustment with documentation or correct field 18 to reflect time of pick-up per trip, per day
1122	Duplicate billing of a miles code has previous been paid.	If multiple trips, "out of base mile", same day, submit an adjustment with documentation
1442	One unit allowed with base code, correct all units on your claim and resubmit	Correct units in field 46 and resubmit as a new claim
1871	Only one ambulance base rate can be billed for the same DOS same hour/time of pick-up	Review your claim for correct HCPC code(s). File as an adjustment when multiple respondents responded, but there was a single transport.
1872	Only 2 HCPC codes allowed for the same DOS, same admit hour.	File as an adjustment with call reports to validate there were 2 separate trips
1874	Only one Ambulance Mileage code can be billed for the same DOS, same hour/time of pick up	Review your claim for correct HCPC code(s). File an adjustment with call reports, to validate there were 2 separate transports
1949	Incorrect combination of HCPC codes	Refer to Appendix A for the acceptable HCPC base and mileage codes
3001	RC and/or HCPC code is missing and/or is an invalid combination. Fields 42 and 44 are required fields	Every RC code entered in FL42 must have a corresponding HCPC code in FL44. Correct and resubmit as a new claim
3002	The level of service billed must be substantiated by the appropriate condition code(s) that describes the recipient at time of pick-up, and treatments administered to the recipient	Review call report to insure your selection of condition codes is as complete as possible (refer to Appendix A). Enter your selections in fields 24-30. You may enter up to 7 condition codes. Submit as a new claim
5001	PA# for state-to-state placement is missing or invalid	Correct field 63. Resubmit as a new claim
5002	The HCPC codes billed do not require PA	Appendix A has the acceptable HCPC codes for billing state-to-state placement

Adjustment Filing

Adjustment or Reconsideration

Complete an Adjustment form to request an adjustment or reconsideration of a previously paid claim. A copy of the claim and related RA page must be attached to the form.

See Attachment A for a sample Adjustment form.

Adjustment Form Instructions

The Medicaid Adjustment form is only to be used to adjust a previously paid claim or to make inquiry about denials not indicated on the list of EOBs.

Do not use the Adjustment form to inquire about a claim or to submit a claim for services that exceed filing time limit.

Attach any RA and medical records related to the adjustment that justifies paying a previously denied claim/detail.

Line	Instruction
Provider Number	indicate billing provider number
Provider Name	enter name of billing provider
Recipient Name	enter recipient's name as it appears on the Medicaid card
Recipient ID	enter the recipient ID number as it appears on the Medicaid card
Date of Service	indicate the specific date of service covered on the original claim
Claim Number	enter the internal claim number (ICN) as indicated on the RA always reference original ICN even if you have a subsequent denied adjustment
Type of Adjustment	indicate reason for the adjustment examples: overpayment, underpayment, full recoupment, etc.
Billed Amount	indicate amount billed on original claim
Paid Amount	enter amount paid on original claim
RA Date	enter the date the original claim was paid
Changes or corrections to be made	indicate reason for the adjustment examples: incorrect units processed and paid, incorrect date of service, third party liability, etc.
Specific reasons for adjustment	indicate reason for the adjustment if adjustment result of procedures not being combined: indicate the codes which are being combined if adjustment is necessitated by incorrect units: indicate total number of correct units as it should have appeared on the original claim, and the correct date of service
Signature of sender and phone number	
Date	indicate date adjustment request is submitted or mailed

Medicaid Inquiry Form

Use the Medicaid Inquiry form to submit claims for:

- time limit overrides
- TPL overrides
- claims requiring overrides prior to processing such as Medicare Part A and B

See Attachment B for a sample Medicaid Inquiry form.

Attach your claim, RAs, and any other related information before submitting.

Medicaid Inquiry Form Instructions

Line	Instruction
Provider Number	indicate billing provider number
Provider Name and Address	indicate billing provider name and address
Recipient Name	enter recipient name as it appears on the Medicaid card
Recipient ID	enter the recipient ID as it appears on the Medicaid card
Date of Service	indicate specific date(s) of service
Claim Number	indicate ICN if the claim was previously processed
Billed Amount	enter total amount billed on the claim
Signature of sender and phone number	

Provider Refunds

Introduction

When processing Medicaid claims, the following can occur: overpayments, third party reimbursements, and incorrect claim submissions. Two methods correct these occurrences: refunds or adjustments/recoupments. This section defines the requirements for issuing refunds to the Medicaid program and how these show on the RA.

Refunds Versus Adjustments

Both refunds and adjustments are acceptable means to reimburse the Medicaid program, the primary difference being where the cash outlay occurs. If adjustments are used, then payments on future RAs are reduced by the requested adjustment amount. Refunds do not affect future Medicaid payments in any way since the reimbursement is made directly from the provider's available funds.

Continued on next page

Provider Refunds, continued

Refund Calculation

Refund the amount as based on the following criteria:

- Duplicate payment–refund the full amount of the duplicate payment
- Overpayment due to incorrect filing of claim, (e.g., billing amount error)–refund the amount of the overpayment (i.e., incorrect Medicaid payment less correct Medicaid payment) or refund the full Medicaid payment and resubmit the claim for repayment
- Recipient liability–refund the amount Medicaid paid for which the recipient is responsible
- Overpayment due to Medicare and Medicaid both paying as the primary insurer–refund the amount of the Medicaid payment that exceeds the coinsurance and deductible of Medicare.
- Other health insurance payment–refund the lesser of the two amounts received not to exceed the Medicaid payment amount, for example:
    - ♦ Amount billed by the provider to Medicaid $150.00
    - ♦ Amount paid by Medicaid $140.00
    - ♦ Amount paid by other health insurance $145.00
    - ♦ Amount to be reimbursed to Medicaid $140.00
    - ♦ Amount kept by provider $145.00

RA Documentation

Attach a copy of the RA to the refund check, highlighting the appropriate recipient and claim information along with the dollar amount of the refund to apply to that recipient. When refunding a particular line item of a recipient claim paid, highlight that specific line item for application of the refund. Without this RA documentation, EDS cannot apply a timely or correct refund. As a result, correct claims payment can be delayed and/or adjustments/recoupments may be processed.

No RA Documentation

If a copy of the RA cannot be supplied, the following information is required to properly apply the refund against the recipient claim history:

- Provider number
- Recipient name and Medicaid identification number (MID)
- Claim number (claim line item number if applicable)
- Date(s) of service
- Dollar amount paid
- Dollar amount of refund
- Reason for refund (brief explanation)

This documentation can be supplied on the Medicaid refund form (DMA-7058) or any available means to the provider.

Action Taken When Refunds Lack Adequate Documentation

When refunds are sent without adequate documentation as indicated above, EDS will send a letter to the provider requesting such documentation. If the documentation is not received within 30 days, EDS will apply these refunds to the determined provider number without detailed recipient claim history. If the refund was sent in error or was adjusted/recouped on a subsequent RA, then researching and resolving these refund inquiries without this documentation is further complicated and delayed. To ensure timely application and to avoid delay in correct claims payment, the required documentation needs to be supplied with each refund.

Continued on next page

Provider Refunds, continued

Where to Send the Refund

Refund checks must be made payable to EDS. Mail the refund, along with the required documentation to the address listed in Appendix B.

Note: If DMA notifies the provider to refund monies, those funds are made payable to DMA and sent to the DMA address indicated in the letter of request.

How Refunds Are Reflected on the RA

Once refunds are entered into the Medicaid system, the following data appears on the RA sent to the provider:

- the Financial Items Section contains a listing of the refunds applied and processed against the recipient claims history as indicated on the refund documentation
- the EOB 113 is displayed for each refund transaction applied stating "refund amount applied to 1099 liability"
- the Claims Payment Summary (last page of RA) indicates the total amount of refund(s) applied in the "credit amount" field, i.e., to give the provider credit for returning those funds
- as a result of returning those funds, the "net 1099 amount" field is decreased by the "credit amount" to ensure the IRS is informed of the correct amount of monies earned and kept by the provider
- refund transactions do not affect the "claims paid," "claims amount," "withheld amount," or "net pay" amount fields of this section (i.e., refunds do not affect the amount paid to the provider but only the amount reported to the IRS)

Tax Identification Information

Tax Information Maintenance

North Carolina Medicaid must have proper tax information for all providers. This ensures correct issuance of 1099 MISC forms each year and that correct tax information is provided to the IRS.

Tax Information Verification

The provider tax name and number (FEIN) Medicaid has on file is on the last page of the Remittance and Status (RA) report. Review the RA through the year for each provider number to ensure the information is correct. Tax information on file may also be verified by contacting EDS Provider Services. See Appendix B.

Group Practice Tax Information

Tax information needed for a group practice:

- group tax name
- group tax number
- attending Medicaid providers in group

Continued on next page

Tax Identification Information, continued

Correcting The Tax Number

Complete a special W-9 for all provider numbers with incorrect information on file. See Attachment D for form. Follow these instructions for completing the special W-9 form:

- fill in Medicaid Provider Name block
- fill in Medicaid Provider number
- Part I Correction field: indicate tax identification number exactly as the IRS has on file for you and/or business. Only sole proprietor or individual may put a Social Security Number
- Part II Correction field: indicate tax name exactly as the IRS has on file for you and/or business
- Part III: indicate appropriate type of organization for the tax identification number **note:** if a Social Security Number is used as a tax identification number, individual/sole proprietor must be selected
- Part IV: an authorized person **must** sign and date the form, otherwise it will be returned as incomplete and the tax data will not be updated

Change Of Ownership

Contact DMA Provider Enrollment to inform of any changes in business ownership. They can assist in enrolling for a Medicaid provider number and ensure correct tax information is on file. If DMA is not contacted and a provider number with incorrect tax data continues to be used, the provider using that number could become liable for taxes on income not received them. See Appendix B for telephone number.

Group Practice Changes

Contact Provider Enrollment to update enrollment and tax information when a provider leaves or is added to the group practice. See Appendix B for telephone number.

Attachments

Attachment A is the Adjustment Form
Attachment B is the Medicaid Inquiry Form
Attachment C is the Provider Certification for Signature on File
Attachment D is the Special W-9, Request For Taxpayer Identification Number Certification
Attachment E is a Sample RA
Attachment F is the UB-92 Claim Form